SECTION D: COST EFFECTIVENESS FOR THE MEDICAID SELECT PCCM PROGRAM:

In order to meet cost effectiveness, a waiver request must demonstrate that the cost of the waiver program during the initial two-year waiver period (Years 1 and 2) was less than the estimated costs of the program without the waiver.

Note that the formal waiver periods for the State of Indiana are:

Year 1: 1/2003 – 12/2003
Year 2: 1/2004 – 12/2004

This waiver request is an initial filing for the populations identified. Base year data was developed from the 12-month period ending March 31, 2002.

Assurance (Please initial or check)

_X__ The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.

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The cost effectiveness demonstration was produced by our contracted actuaries, Milliman USA, Inc. using the CMS spreadsheets provided in the preprint application.

I. Reimbursement of Providers

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe). Responses must match those provided in Section A.II.c.6:

a. _x_ Management fees are expected to be paid under this waiver. The management fees were calculated as follows.

1. _x_ First Year: $4.00 per member per month fee

2. _x_ Second Year: $4.00 per member per month fee

3. N/A Third Year: _____ per member per month fee

4. N/A Fourth Year: _____ per member per month fee

II. Member Months: Appendix D.II

Purpose: To provide data on actual and projected enrollment during the waiver period. Actual enrollment data for the previous waiver period must be obtained from the State's tracking system. Projected enrollment data for the upcoming period is needed to determine whether the waiver is likely to be cost effective. This data is also useful in assessing future enrollment changes in the waiver.

Appendix D.II corresponds to the Waiver Years 1-2. Member months have been maintained equal to the base year data for waiver years 1 and 2. Actual enrollment will occur on a phase-in basis during waiver year 1.

Step 1: Please list the eligibility categories and rate cells for the population to be enrolled in the waiver program.

The PCCM fee will be paid uniformly for all aid categories associated with the Medicaid Select program. The cost effectiveness calculations separate the populations into the following groupings.

- Old Age Assistance
- Blind and Disabled – Non-Dual
- Blind and Disabled – Dual
- Spend-down – Non-Dual
- Spend-down – Dual
- Other (primarily children population)

Step 2: See instruction box. If the State estimates that all eligible individuals will not be enrolled in managed care (i.e., a percentage of individuals will be unenrolled because of eligibility changes and the length of the enrollment process) please note the adjustment here:

Due to the length of the enrollment process, the state anticipates that there will continue to be some periods of non-waiver enrollment within the mandatory population. The periods of non-waiver enrollment will be length of time required for an enrollee to choose a primary care physician.

Step 3: See instruction box. In the space provided below, please explain any variance in member months, by region, from Year 1 to Year 4.

All results have been presented on a Statewide basis.

Step 4: See instruction box. In the space provided below, please explain any variance in total member months from Year 1 to Year 4.

Projected enrollment has been maintained level for Years 1 and 2.

a. Population in base year data

1._x_ Base year data is from the same population as to be included in the waiver.

III. Without Waiver Data Sources and Adjustments: Appendix D.III

Purpose: To explain the data sources and reimbursement methodology for base year costs.

To identify adjustments which must be made to base year costs in order to arrive at the without waiver costs for all waiver services.

To identify adjustments that will affect the With Waiver Costs.

State Response to These Adjustments Is Required

a. Copayment Adjustment: (Appendix D.III, Line 44).

3._x_ The State has chosen not to make this adjustment.

Both the without waiver and with waiver experience is reported net of copayments. Because of this consistency, it was determined that an adjustment was not necessary.

b. Incurred but not Reported (IBNR) (Appendix D.III, Line 45):

1._**X**_ IBNR adjustment was made. Please indicate the number of years used as basis: ___four__ .
i._x_ Claims in base year data source are based on date of service.

ii.___ Claims in base year data source are based on date of payment.

Methodology:

1._x_ Calculate average monthly completion factors and apply to the known paid total to derive an overall completion percentage for the base period.

c. Inflation (Appendix D.III, Line 46):

Basis:

1._x_ State historical inflation rates

(a) Please indicate the years on which the rates are based: Inflation base years:

Data was used from October 1998 through March 2002.

(b) Please indicate the mathematical methodology used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

Rolling Averages Method on Estimated Incurred Claims.

Inflation rates were developed by comparing historical costs on a PMPM basis from October 1998 through March 1999 to October 2001 through March 31, 2002. Adjustments to the trend rates were applied to reflect fee screen changes, seasonality, and other policy changes.

d. Payments / Recoupments not Processed through MMIS (Appendix D.III, Line 47):

1._X_ Payments outside of the MMIS were made. Those payments include (please describe):

Recoveries due to third party liability collections was reflected at a rate of 1.4%.

Recoveries due to the pharmacy rebate was reflected at a rate of 18.5% of pharmacy costs.

There were no other recoupments or payments outside of MMIS.

Optional Adjustments

Note: These adjustments may be made based upon the State's own policy preferences. There is no HCFA preference for any of these adjustments. If the State has made an adjustment to its without waiver cost, information on the basis and methodology used is required and must be mathematically accounted for in Appendix D.IV. If the State has chosen not to make these adjustments, please mark the appropriate box.

a. PCCM Savings Adjustment (Appendix D.III, Line 48): This adjustment is to be made when States have had a PCCM program in place for several years or when the State has had a combined MCO/PCCM program. The case management fees need to be deducted from without waiver costs.

2. _X_ This adjustment was not necessary because the State used MMIS claims exclusive of any PCCM case-management fees.

b. Pooling for Catastrophic Claims (Appendix D.III, Line 49): This adjustment should be used if it is determined that a small number of catastrophic claims are distorting per capita costs in some rate cells and are not predictive of future utilization.
Methodology:

2. _X_ The State has chosen not to make adjustment.

c. Pricing (Appendix D.III, Line 50): These adjustments account for changes in the cost of services under FFS. For example, changes in fee schedules, changes brought about by legal action, or changes brought about by legislation.
Basis:

5. _X_ The State has chosen not to make adjustment.

d. Programmatic/policy changes after claims extraction (Appendix D.III, Line 51): These adjustments should account for any FFS programmatic changes that are not cost neutral and affect the without waiver costs. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program.
Basis and Methodology:

2._X_ The State has chosen not to make adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

e. Regional Factors applied to Small Populations (Appendix D.III, Line 55): This adjustment is to be applied when there are a small number of eligible months in certain rate cells and large variations in PMPMs across these categories and regions exist.
Methodology:

2._X_ The State has chosen not to make adjustment.

f. Utilization (Appendix D.III, Line 56): This adjustment reflects the changes in utilization of FFS services between the Base Year and the beginning of the waiver and between Years One and Two of the waiver.

3._X_ Other (please describe):
Adjustments to the with waiver costs have been made for utilization due to the implementation of the PCCM program. No utilization adjustments were made for the without waiver costs.

h. Data Smoothing Calculations for Predictability (Appendix D.III, Line 59): Costs in rate cells are smoothed through a cost-neutral process to reduce distortions across cells and adjust rates toward the statewide average rate. These distortions are primarily the result of small populations, access problems in certain areas of the State, or extremely high cost catastrophic claims.
Basis and Methodology

2._X_ The State has chosen not to make adjustment.

V. With Waiver Development: Appendix V.

Purpose: To calculate costs with the waiver on a PMPM basis. With waiver costs are the sum of payments to providers, management fees, and the costs to the State of implementing and maintaining the managed care program.

a._X_ The State assures HCFA that the costs with the waiver will be equal or less to costs without the waiver.

b. Please explain how the State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may

monitor monthly PMPM with waiver cost reports or the State may conduct periodic mock cost-effectiveness tests):

As part of the quarterly budget analysis, the claim costs by benefit category for the State's aid categories are compared to determine cost-effectiveness.

Step 26: List and include all waiver administrative costs. Please describe below any unusal contracts entered into as part of the waiver program or the absence of any expected costs (such as, systems modification, enrollment broker, consultant, independent assessment, utilization review system, quality assurance review system, contract administration, additional staff, hotline operation):

Direct Administrative Expenses are the costs associated with data management, the enrollment broker, the actuary, and EQRO. Further, because the PCCM waiver program claims are processed on a fee-for-service basis, there will be indirect expenses associated with the MMIS system.